1995

San Francisco HIV Prevention Plan

A Product of the

HIV Prevention Planning Council

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EXECUTIVE SUMMARY

A. Introduction

This HIV Prevention Plan, the first of its kind in San Francisco, is a significant product of a community planning process which began in early 1994. The AIDS Office of the San Francisco Department of Public Health, responding to a Request for Proposal issued in late 1993 by the Centers for Disease Control and Prevention (CDC), applied for moneys to be specifically dedicated to the initiation of a community-wide process leading to the development of an HIV Prevention Plan for San Francisco. With approval of that proposal and operating under guidelines issued by the CDC, the AIDS Office created a new community planning body. In an effort to make that body representative of San Francisco's diverse communities, nominations were sought from prevention providers, researchers/educators, and the general community. From the 93 nominations received by the deadline, a screening committee (composed of the chairs/co-chairs of the AIDS Prevention Advisory Committee, Ryan White CARE Council, and the People of Color Advisory Committee) forwarded 37 names of individuals representing as many aspects of the city's population as possible to the Directors of the Department of Public Health and the AIDS Office for consideration and possible appointment. All 37 persons were appointed and officially became members of a new HIV Prevention Planning Council (HPPC).

The membership of the HPPC was designed to closely reflect the characteristics of the HIV epidemic (both current and projected) in San Francisco. It is ethnically diverse (with 7 African American members; 7 Latino members; 5 Asian/Pacific Islander members; 2 Native American members and 13 White members as of 8/31/94) and represents the sexual orientation diversity of the City (12 gay/bisexual men; 4 lesbians; and 1 transgender woman are members of the council). People with HIV/AIDS are also among the members.

In its first few months of operation, the HPPC was faced with the formidable task of developing (by the end of September, 1994) an HIV Prevention Plan which addressed: the epidemiology of HIV/AIDS in San Francisco; prevention resources currently available in the community; prevention strategies and interventions; prevention goals, objectives and linkages; an assessment of needs for defined populations; proposed criteria for establishing priorities; technical assistance needs of prevention providers (and the AIDS Office); and evaluation. To enhance this process, consultants from the

Support Center for Nonprofit Management were retained under a sole-source contract with the AIDS Office.

Three co-chairs (one designated by the AIDS Office and two selected by the HPPC (from the community) to facilitate the plan development process. The co-chairs, recognizing the need to move speedily, decided to create sub-committees which would be responsible for development of the individual elements of the plan. The sub-committees (Epidemiology and Needs Assessment; Strategies and Interventions; Goals and Objectives; Criteria for Priority Setting; and Technical Assistance) had their membership expanded (beyond the HPPC membership itself) to include interested members of the community at large. Sub-committee meetings were held at least twice a month; HPPC meetings were held twice a month during the plan development period.

As each chapter was developed, public input was solicited through public meetings, focus groups and meetings of the various bodies that serve in an advisory capacity to the AIDS Office. The input from these efforts was provided to the sub-committees where decisions were made about inclusion of the information before the draft chapter was presented to the full council by the chair of the appropriate sub-committee with back-up and support from other members of the sub-committee. Each chapter was voted on and either approved or sent back to the sub-committee for revision. The result of this feverish activity by HPPC members, community members who served on HPPC sub-committees and members of the public who participated in focus groups and community meetings is this comprehensive HIV Prevention Plan for San Francisco.

B. What is the HIV Prevention Plan?

The HIV Prevention Plan is largely about helping HIV prevention providers get better organized (i.e. finding out what we know, what we don't know, what is working and what is not working) through meaningful planning for and evaluation of the prevention system in San Francisco. It is an effort designed to implement strategies and interventions which will ultimately stop the spread of HIV in the City. It defines unmet prevention needs as well as the existing "known" needs, emerging trends, the data we now have and don't have, as well as the data that is needed. This plan represents a shift in the basic assumptions underlying HIV prevention planning. Formerly, prevention efforts were directed to defined "high-risk" population groups without regard to what actually put those populations at risk. This plan addresses the HIV prevention needs of various populations on the basis of

their high-risk sexual and drug using behaviors. It recognizes that behavior is what puts people at risk -- not the fact that they belong to a particular ethnic, cultural, or other group.

C. What Does the HIV Prevention Plan Include?

The HIV Prevention Plan consists of nine (9) chapters covering: the epidemiologic profile of HIV/AIDS in San Francisco; an inventory of prevention resources; HIV prevention strategies and interventions for target populations; the criteria used in setting priorities; a comprehensive summary and needs assessment; priority goals and objectives; system linkages and coordination; technical assistance for community based organizations and other HIV prevention providers; and an evaluation of the process by which the plan was developed. Following is a brief synopsis of each chapter:

CHAPTER 1: EPIDEMIOLOGIC PROFILE

This profile reflects the current and future HIV/AIDS epidemic in San Francisco. As the cornerstone of the Plan, it is probably the most comprehensive analysis of HIV/AIDS among San Francisco's multiple transmission groups. These groups, as identified by the HIV Prevention Planning Council (HPPC), emphasize the need to organize epidemiological data and characterize the risk of infection based on behavior rather than the traditional "risk" groups that have been used in the past. When information regarding the transmission groups is compared with behavior and transmission activity (e.g. blood-to-blood, semen to blood, vaginal secretions to blood) some clearly defined high risk target populations do emerge.

The transmission groups approved by the HPPC for the Epidemiologic Profile are:

- women who have sex with women
- women who have sex with women and inject drugs
- women who have sex with men and women
- women who have sex with men and women and inject drugs
- women who have sex with men
- women who have sex with men and inject drugs
- men who have sex with women
- men who have sex with women and inject drugs
- men who have sex with men and women
- men who have sex with men and women and inject drugs
- men who have sex with men
- men who have sex with men and inject drugs

The high risk target populations (discussed in detail in Chapter 5) which emerge from a review of the sociodemographic, behavioral, and epidemiologic indicators of HIV risk are:

- Injection drug users
- Gay Men
- Youth
- Women
- Transgendered Male-to-Females
- Homeless Adults
- Immigrants
- Incarcerated Adults

In addition, the Epidemiologic Profile presents information/data from HIV Counseling and Testing, a comprehensive list of published Behavioral Studies and Surrogate Markers. Readers may find the Epidemiologic Profile in Chapter 1 of the Plan.

CHAPTER 2: RESOURCE INVENTORY

The CDC Guidance mandates the creation of an inventory of resources currently in use in San Francisco, and an analysis of the effectiveness of the strategies and interventions these resources support. Because no standardized format is available from which to develop a comprehensive inventory of all HIV prevention resources (including those agencies which do not receive CDC or State of California funds) in San Francisco, the picture remains incomplete. Chapter 2 of the plan summarizes what prevention providers have reported about what prevention programs and activities they provide, what population groups they have targeted, and who they actually served in the previous year. Ideally, such an inventory would identify gaps in services but, because of reporting problems, resource gaps remain unidentified.

CHAPTER 3: STRATEGIES AND INTERVENTIONS

This chapter offers findings about current and future strategies and interventions, and about the ideas and opinions of members of target populations, prevention providers and funders. This chapter also identifies a number of *overarching themes* which have considerable relevance in any discussion of HIV prevention strategies and interventions. These include:

- HIV prevention strategies targeting IDU activity must also address sexual behavior modification;
- HIV prevention strategies must address non-IDU substance use issues as well as IDU activity;
- HIV prevention messages must reach beyond behavior modification to address sociological and psychological issues such as self-esteem and the importance of community membership;
- Information on prevention services and programs must be gathered in a manner which enables measurement of unmet needs;

- Services must be targeted at who is at highest risk and perceptions of service decisions must be need-based;

- Information and education about HIV transmission must be delivered in a clear, concise, consistent, and culturally appropriate manner.

This chapter also includes a brief discussion and assessment of each of the major HIV prevention strategies currently in use in San Francisco. These include:

- HIV counseling, testing, referral and partner notification (CTRPN);
- Individual level interventions
- Group level interventions
- Community level interventions
- Public Information programs

CHAPTER 4: PRIORITY SETTING CRITERIA

This chapter identifies criteria for selecting priorities in four areas: target groups, strategies, resource allocation and research. In each instance, the criteria are preceded by guiding principle(s) for using the criteria. These principles are:

a. Target Groups: There is only one factor for determining which populations need focused prevention efforts; namely a significant risk of contracting HIV. Risk of contracting HIV is caused by practicing certain, identifiable behaviors.

b. Selection of Strategies: Strategies will be consistent with the values, norms, and consumer preferences of the intended target population.

c. Resource Allocation: To prevent as many infections as possible with limited resources, intensive prevention efforts should be targeted to groups and individuals at higher risk. Basic, non-targeted prevention information and activities must be available at some level to every individual or group no matter how small the risk. Other resources need to be mobilized to assure that all needs are identified and addressed.

d. Research Priorities: The guiding principle is to find out what we most need to know about populations at high risk and populations which may be a high risk but about which there is little data.

CHAPTER 5: SUMMARY AND NEEDS ASSESSMENT

This chapter presents an extensive discussion of those communities/ target populations at highest risk for HIV transmission in San Francisco. It includes an introduction to the population, unmet needs that have been identified and recommendations for prevention. The specific population groups (which emerged from the data in the Epidemiologic Profile) are:

- Injection drug users
- Gay Men
- Youth
- Women
- Transgendered Male-to-Females
- Homeless Adults
- Immigrants
- Incarcerated Adults

The principal conclusion in this chapter is that issues of self esteem, mental health, poverty, homophobia, racism, and sexism are issues which have plagued communities long before the onslaught of AIDS. What makes AIDS prevention planning so difficult is that the causes of risky behavior are so inextricably linked with these larger social issues. Therefore, in order to effectively address behavior change to stop risky behavior(s) among the groups listed above, these larger issues also must be directly addressed. It is recognized that the recommendations included in this chapter will require great time and effort to accomplish. What is particularly important is that these recommendations are viewed from the proper perspective. None of us expects that issues such as self esteem and homophobia will be solved in one year or ten years. What we do expect is that small, measurable steps towards solving these problems can be developed, implemented, and evaluated by HIV prevention planners in a realistic and timely fashion.

The final recommendation of this chapter, and perhaps its most crucial one, is that the HIV prevention planning process and all those who have participated in it, is recognized and accepted as the first small step in a very long process. This process, which has raised more questions than it has

answered, requires a commitment towards working for the answers to those questions and an acceptance of prevention planning as part of the permanent HIV prevention process.

CHAPTER 6: GOALS AND OBJECTIVES

The HIV Prevention Planning Council, in adopting the planning goals and objectives, and the AIDS Office, in incorporating them into its operational programs, have accepted the fact that HIV prevention can only be successful if it focuses on the behaviors that place people at risk for HIV transmission. This chapter of the HIV Prevention Plan places emphasis on the standardization of essential aspects of HIV prevention so that meaningful planning and evaluation can take place at the system level.

Five goals (with supporting objectives) have been put forward. These are:

- Reduce new HIV infections in the City and County of San Francisco to as close to zero as possible by the year 2000. To do this, we will target both HIV-positive and HIV-negative communities.
- Standardize units of service definitions for HIV prevention services by the end of 1995, so that the work of different providers can be looked at in the context of the overall prevention effort in the City.
- Make evaluation possible: establish a standard evaluation system for prevention efforts.
- All HIV prevention providers in San Francisco will have the technical and administrative capabilities to provide competent and appropriate prevention programs.
- Prevention efforts shall be culturally appropriate.

CHAPTER 7: SYSTEM LINKAGES AND COORDINATION

This chapter identifies the coordination and linkages between the AIDS Office, local government, HIV prevention providers, the private sector, and the broader community necessary to facilitate the accomplishment of the Goals and Objectives outlined in the Plan. Toward this end, the goal of cultural competence and the specific objective regarding the coordination of

primary and secondary prevention efforts guide all of the activities outlined in this section of the Plan.

CHAPTER 8: TECHNICAL ASSISTANCE

This section of the Plan addresses the technical assistance needs of prevention community based organizations, other service providers, and the AIDS Office. It focuses on the provision of training or expertise that will help agencies to plan, implement, and evaluate their HIV prevention efforts more effectively.

CHAPTER 9: EVALUATION

This chapter recognizes the fact that evaluation is both useful and necessary. It indicates that evaluation is a quality assurance method for determining the effectiveness of (in this instance) the planning process and serves as a monitoring tool to measure success, to inform decision-making, and to direct necessary changes in the process.

The evaluation is designed to:

- Document that the community planning process actually took place.
- Determine whether or not the short-term program goals of the planning process were met.
- Identify strengths and weaknesses of the planning process.

As part of the process, the plan details three phases of evaluation:

Phase I: evaluation of the community planning process which led to the development of this plan.

Phase II. evaluation of the contractual services of the subcontractor/consultant.

Phase III. evaluation of the implementation of the recommendations and priorities described throughout the plan.

EXECUTIVE SUMMARY FOR PUBLIC HEARINGS

Introduction

Everyone in San Francisco has a vital stake and a role in the development of a viable, efficient community-based HIV prevention program. Regardless of race, age, gender, or sexual orientation, HIV and AIDS impact upon all aspects of our city and our communities. The need for an effective prevention program is of particular importance in San Francisco, where the high presence of the virus makes the opportunity for transmission and infection a critical, continuing timely issue.

The importance of health and academic institutions and community organizations in contributing to the development of an effective planning process is well supported by both research and practice. In order to be effective, programs and policies for HIV prevention must be responsive to the daily realities of peoples' lives. Culturally competent planning must take into account such frequently encountered issues as substance use, sexual experimentation, mental health and self-esteem, and poverty. Yet, until now, broad-based community participation has not been invited or fully acknowledged in community planning efforts.

In late 1993, the Centers for Disease Control and Prevention awarded 65 grants across the country for the specific purpose of creating community-wide planning processes for HIV prevention. Within California, the cities of Los Angeles and San Francisco, as well as the State of California, were recipients of CDC funding.

The 37-member HIV Prevention Planning Council (HPPC), was formed early in 1994. Specifically chosen to reflect the characteristics and diversity of the HIV affected communities in San Francisco, the HPPC is responsible for the overall task of developing the city-wide prevention plan. Under CDC guidelines, the plan must address the following specific issues: the epidemiology of HIV/AIDS in San Francisco; current strategies and interventions used to fight the spread of the epidemic; a model for establishing priority criteria and target populations with the affected communities; and the technical assistance needs of grantees and prevention providers.

In order to be effective, community planning is a continually evolving process. Planning must result in HIV prevention programs which address the prevention

needs of the community. The planning process must be responsive to the changing dynamics of pre-existing needs being met and new HIV needs being identified.

In anticipation of this "cycle of needs," the HPPC viewed its charge in 1994 to be that of building the foundation upon which future planning can be based. Towards that goal, much of this year's plan asks the question, "What is the information that we need to know in order to create and implement effective HIV prevention programs in San Francisco?" The gathering and analysis of this information will continue through 1995 and beyond, because the CDC and the HPPC members believe that better information will lead to better and more effective programs.

Some vitally important information has already been gathered this year. For the first time, this 1995 plan presents a comprehensive epidemiologic profile of HIV and AIDS infection within the city. In addition, the plan incorporates an assessment of what information is and is not available within the city regarding prevention services and planning. Because each chapter of the plan builds upon the next, it is critical that no one chapter be read independently of the others. One of the recommendations which recurs throughout the plan is that of suggesting important research and information-gathering needs which will lead to more informed, thoughtful planning in the future.

It is therefore important that the 1995 plan be seen as a beginning rather than an ending. This year's plan is largely about getting the system organized (i.e. finding out what we know and don't know, what is and is not working, etc.) so that we can do meaningful evaluations, and subsequently, meaningful planning, to stop the spread of HIV in San Francisco. The publication of this plan is therefore merely the first, crucial step in a process which has as its goals both short-term recommendations, and long-term strategic planning implications.

Both goals are equally important. The personal suffering and shortened lives which individuals with HIV and AIDS must endure is, for many seemingly unaffected by the disease, beyond understanding. And yet all of us, infected or not, pay heavily for the losses which HIV transmission exacts from our communities. We pay in diminished economic productivity of an entire generation, and the potential to lose that productivity from future generations. We pay immense social costs by somehow having to find the means to grapple with our own personal grief and loss as we watch friends, lovers, co-workers, and family become infected or succumb to AIDS. And we pay the moral costs of knowing that every time another of us becomes infected, there is someone who asks, "What could I have done to prevent this from happening?"

These outcomes can be reversed. But to do so, we must all make a concerted effort to create communities that actively seek to develop commonalities from our differences, to recognize that our battles must be waged against the disease and not each other, and to support education, promote health, and provide every opportunity we can to stop even one more person from becoming infected.

Overarching Themes

Throughout the course of developing this plan, several overarching themes emerged. These are the themes which arose in one section of the plan (for example, in the development of the Epidemiologic Profile), and then resurfaced repeatedly in other areas of the plan (i.e. the Goals and Objectives, or the Resource Inventory). As such, these themes form the basis from which needs and recommendations for action arise.

* Behavior is the Primary Emphasis When Assessing Degree of Risk for HIV Transmission and Infection.

The Council decided to make a serious shift in the way HIV risk has traditionally been assessed. Instead of looking at risk by sociodemographic status (e.g. race/ethnicity), as has been commonly done in the past, the council chose to prioritize risk by the most efficient to the least efficient modes of HIV transmission (e.g. blood to blood, semen to blood, or vaginal secretion to blood transmission) and the behaviors that lead to transmission (e.g., sharing needles without cleaning them, unprotected anal intercourse). By so doing, the council is focusing first upon overarching themes of transmission which affect all groups, and then looking at how particular behavioral risks are increased by actions which are particular or more pronounced within target populations.

* Target Groups are Identified in Order to Assess Who is at Risk, but NOT to Prioritize Relative Risk Between These Groups.

The plan does examine which groups in general are at higher risk. What the plan does not do is try to prioritize relative risk between target groups. Therefore, the plan does say that injection drug users are at higher risk than non-IDU men who have sex with women, but it does not say if IDUs are at higher risk than gay men, nor does it try to make comparisons between specific groups.

* **HIV Prevention Strategies Targeting Injection Drug Use Must Also Address Sexual Behavior.**

For every target population, regardless of race, ethnicity, gender, or age, the highest risk of HIV infection occurs among injection drug users (IDU) who have sex with men. In addition, IDUs are disproportionately represented among homeless and transient populations. And for every one of these populations, IDUs regularly report that although they often adapt their IDU behavior to incorporate safer drug use, they just as often do not modify sexual behavior to engage in safer activity.

In order to be successful, then, programs targeting IDUs must address HIV infection in the larger context of how the disease affects their daily lives, and not just how a particular manifestation of behavior might be altered by a specific intervention. For instance, the problem of IDUs engaging in high risk sex cannot be solved simply by handing out condoms. While at first glance this may seem to be a logical intervention, it addresses only the fact that IDUs engage in sex, and ignores the greater, more important issues of when and how IDUs engage in risky behavior. It is not realistic to expect people who engage in sex while under the influence of drugs, or those who must trade sex in order to get drugs, to demand condom use under these situations.

* HIV Prevention Strategies Must Address Non-IDU Substance Use Issues as well as IDU Activity.

Initial research indicates that non-IDU substance-using populations may be at high risk for HIV infection. Many of the issues linking IDU activity with unsafe sex also apply to non-IDU substance users and unsafe sex. Like strategies designed to target IDUs, programs aimed at other substance users must address not only how users engage in sex, but why and under what circumstances they do so.

In order to do so effectively, there is a need to institutionalize HIV primary prevention programs within substance abuse treatment agencies. Substance use programs which include condom distribution in conjunction with education, street outreach, and referrals for mental health and treatment will more closely meet the needs of substance users. And because substance abuse agencies are a point of entry and way of reaching individuals who may be at high risk for HIV infection, training staff in HIV prevention is critical. Interventions must be designed with the end result of helping users to develop skills for having and maintaining sober sex, since relapse of one type of behavior may mean relapse into another.

* **HIV Prevention Messages Must Reach Beyond Behavior Modification to Address Sociological and Psychological Issues Such as Self-Esteem and the Importance of Community Membership.**

Prevention strategies and interventions often focus exclusively upon altering behavior, and not upon altering the sociological and psychological factors which may influence that behavior. Educational information about the causes and methods of HIV transmission will, in and of themselves, do little to change peoples' behavior. In parts of the gay male community, even though a high level of knowledge about HIV transmission exists and condom use and safe sex practices have increased, a high degree of unsafe sex still occurs.

Researchers and social scientists believe that this barrier between knowledge and action, or between information and implementation, is in part caused by sociological and psychological pressures which discourage safe sexual practices. For instance there already exists a growing perceived cultural division in the gay community between HIV positive and HIV negative gay men. Focus group participants and providers alike report that the emergence of these two subcultures has created a sentiment within parts of each subculture that men are not really part of the gay community unless they are seropositive.

People at risk for HIV infection report other societal influences which inhibit prevention efforts. Many gay men believe that seroconversion is inevitable, and some believe that they will feel a sense of relief and stability once that line is crossed. This stability can be perceived as desirable when compared to the uncertainty and difficulty associated with remaining HIV negative. In order to be effective, then, HIV prevention programs must address a broader range of psycho-social needs within affected communities.

* Programs Must be Targeted at Who is At Highest Risk, and Perceptions of Service Decisions Must be Need-Based.

In the past, identification of priority populations and priority interventions was mainly defined by the State and Local health departments based on the best available data. There were often many factors that directly influenced these decisions and unfortunately, those factors often had no relevance to sound public health practice. The situation was compounded by the lack of complete information on various populations, particularly injection drug users, female partners of IDUs, and gay men of color. These and other factors resulted in the delayed identification of some at-risk populations.

Today, prevention planners have the opportunity to learn from the experience of the past. Community planning has changed the very framework in which decisions are made. There is now a partnership between infected individuals, affected communities, prevention providers, researchers, public health officials, and others. There is greater knowledge on populations at risk for HIV infection. By no means is there enough data on all populations, but planning is at a point where planners can begin to focus on the behaviors that place people at risk for HIV infection. Planners can begin to identify research priorities. They can tap the wisdom of all who have been involved in community planning, from the executive director to the outreach worker. It is the culmination of these factors which will eventually lead to HIV prevention priorities being based upon sound public health policies -- where HIV prevention interventions are targeted to those at highest risk and with the greatest need for health education and health promotion.

* Education about HIV Transmission Must be Delivered in A Clear, Concise, Consistent, and Culturally Appropriate Manner.

All populations, regardless of risk need appropriately designed prevention education. While some of these needs can be met only through interventions tailored to very specific sub-group requirements, there are some over-arching needs which crossover to all communities. For instance, prevention providers must present uniform, unambiguous, non-contradictory data about safe and unsafe behavior. Prevention service clients report that with regard to certain behaviors (most notably oral sex), they feel overwhelmed by the amount of information which they get, much of what they perceive to be contradictory.

* Behavior Change Must be Targeted at Both Group and Individual Norms.

All communities have difficulty in taking responsibility for changing individual behavior, particularly if the wider peer, cultural, and social groups within which the individual mores are not receptive to that behavior change. For instance, it is difficult for gay men to consistently practice safer sex in an environment which often measures acceptance by sexual activity. In order for strategies targeting individual change to be effective, those strategies must be developed in conjunction with larger community-change oriented interventions which have the same message, goals, and means of achieving the desired outcomes.

* Whenever Possible, Prevention Messages and Education Must be Delivered by Community Peers.

In HIV prevention, the messenger is as important as the message itself. People inherently place greater trust in messages delivered by people who look like them, act like them, live where they live, and speak their language. Many people also report being powerfully affected by HIV prevention messages delivered by HIV positive peers. The ability to self-identify with a person, to be able to say, "This could be me," is, for many, the strongest prevention message available.

* HIV Prevention Strategies Must be Based Upon a Health Promotion Model.

For HIV prevention efforts to make demonstrable reductions in the number of new HIV infections, strategies previously designed using the Disease Prevention Model must be reexamined. Based on clinical outcomes, the Disease Prevention Model has been shown to be inherently flawed when applied to HIV strategies. In its place, the HPPC has chosen to follow a Health Promotion Model. Health Promotion and Health Education Models recognize the value in keeping individuals from becoming infected in the first place. The focus is on health, not sickness. Therefore, by placing emphasis on behaviors, as the HPPC plan does, the psychosocial and sociodemographic barriers to behavior change can be assessed, and interventions can be designed to enable individual and community level changes.

Unmet Needs and Recommendations for Action

* Information on Prevention Services and Programs Must be Gathered in a Manner Which Enables Measurement of Unmet Needs.

One of the most difficult issues in assessing unmet needs is that of accurate measurement of needs which are being met. This problem is heightened in a city like San Francisco where, because of the intensity and volume of AIDS-related research being conducted here, there exists a misperception that such information is readily available. A powerful barrier to changing the current information-gathering infrastructure, then, is this deep-rooted assumption that permeates the HIV Prevention Planning community that comprehensive information does exist somewhere, somehow, and that it will turn up later if one looks hard enough. This misperception often makes people believe that

resources are better spent in areas other than data-gathering, particularly if they are convinced that the data already exists.

A great unmet need, then, is the creation of a uniform, mandatory system of data gathering and reporting, which will better enable prevention planners to assess the current system of prevention services in San Francisco. In many instances, the changes which are needed are minimal; in some cases, all it will take will be making some optional reporting requirements mandatory, or adding a section to the quarterly reporting requirements. In other areas, such as non-government funded services, the change will require greater coordination with funders and grantmakers. Either way, the change is necessary not only to provide planners with better decision-making potential, but also to help debunk the myth that planners are currently working with complete information.

* Current Strategies and Interventions Must be Re-assessed in Terms of Their Broad-based Efficacy.

Both current and proposed strategies and interventions for HIV prevention must be examined in order to assess their efficacy as elements of a comprehensive planning strategy. Because the HPPC plan for 1995 recommends that prevention be perceived in the larger contexts of psychosocial care and health promotion, strategies and interventions must also meet this requirement. In the past, interventions were often designed with a specific action in mind (e.g. use a condom during anal sex), without taking into account the greater context of how and why behaviors occur (e.g. people are less likely to use condoms when under the influence of alcohol or drugs). In order for strategies and interventions to be successful, <u>all</u> interventions must be re-examined for this contextual component. Those which address broad-based contextual issues should be maintained and expanded. Those which do not take a holistic approach must be modified if possible, and terminated if modification is not an option.

* Monitor Programs Frequently, and Provide Timely, Comprehensive Technical Assistance Interventions to Service Providers.

The 1995 HPPC plan calls for service providers to make several changes to the way services are currently delivered. A cornerstone of this recommendation is the need for prevention messages to be delivered in a clear, consistent manner. Another is the desire to involve more HIV-positive people in prevention planning and service delivery. Coordination and training for service providers is a primary need, as is frequent monitoring and assessment of providers as they incorporate change. Part of the 1995 HPPC plan specifically mandates technical

assistance training to providers; the programs developed as part of the plan should be expanded and maintained in future years.

* **Develop and Implement Comprehensive Evaluation and Assessment Tools to Measure Prevention Service Provision.**

A primary unmet need within the HIV prevention planning structure in San Francisco is that of uniform, comprehensive data gathering, evaluation, and assessment tools. There are currently no such specific requirements mandated by any governing or funding body, public or private, within the city of San Francisco. While certain bodies, such as the AIDS Office, do require the filing of quarterly reports and other reporting demands, there is little uniformity in how these guidelines are fulfilled. This results in overcounting of some services and undercounting of others.

Moreover, there is little, if any, information available on privately funded prevention programs. For this reason, an accurate assessment of the scope and efficacy of prevention programs in the city is nearly impossible to generate. In order to develop effective policies, a clearer baseline analysis of services must first be generated. Uniform, standardized reporting techniques will make such data-gathering possible.

* Greater Data-Gathering for All Communities Affected by HIV.

An unmet need which is raised throughout the Epidemiologic Profile and Behavioral Summary is that of more comprehensive data-gathering. The Epidemiologic Profile highlights the fact that for some populations, almost no informational data exists at all. For instance, there is not even an accurate count of the number of transgendered people currently living in San Francisco. For other populations, such as gay men, there is a great deal of information, but categorization is widely splintered (e.g. some studies include bisexual men with gay men, others do not).

Uniform data-gathering in specific areas highlighted by the Epidemiologic Profile will result in better defined, more comprehensive statistical information which will in turn lead to better designed, more comprehensive prevention planning programs.

* Continuously Assess Unmet and Met Needs.

As prevention programs are developed, implemented, and reach their goals, the spectrum of met and unmet needs for HIV prevention planning will shift as old needs are met and new needs arise. In order to insure that highest priority is being given to the greatest unmet needs, a structured, uniform method of evaluating met and unmet needs must be developed and implemented through a process which involves community members, researchers, and government policy makers at all levels.

Structure of The Plan

The HPPC Prevention Plan is divided into nine chapters. As mentioned elsewhere in this document, each of these chapters builds upon and should be viewed in conjunction with the others. As such, it is critical that no single chapter be read independently, or be perceived as holding greater or lesser weight than the other chapters. The nine chapters are presented in the following order:

Chapter 1: Epidemiologic Profile and Behavioral Summaries
Chapter 2: Resource Inventory of Current HIV Prevention Services
Chapter 3: Current HIV Prevention Strategies and Interventions
Chapter 4: Priority Setting Criteria
Chapter 5: Needs Assessment
Chapter 6: Goals and Objectives
Chapter 7: System Linkages and Coordination
Chapter 8: Technical Assistance
Chapter 9: Evaluation

Conclusion: Transforming Risk Into Opportunity

An effective community planning process for HIV prevention will be in the forefront of action to bring challenging and coherent programs to today's communities at risk for HIV infection. But they cannot do the job alone. The work of developing programs and policies that respond to the needs of communities at risk must be embraced by all concerned groups and citizens.

The dedication and commitment of each of these sectors is needed to achieve a new understanding of and appreciation for the complexity of an issue such as HIV prevention. But understanding and appreciation by themselves are not enough; they must lead to action. We can tackle the vast problem of reforming and restructuring how we wage our battle against HIV as long as we set our minds to the task. At the end of the nineteenth century, changing social norms and a public outcry against stagnant and ineffective societal tools of change resulted in the Progressive Era, and sweeping social change that resonated throughout every aspect of American life: law, government, education, and social welfare.

Although different in nature and scope, we are at another crossroads when sweeping change is demanded. Fifteen years into the AIDS epidemic, no cure is in sight, while new infections continue to occur. It is time that we rethink and redesign the weapons with which we will wage the battle for prevention. And it is from the communities at risk and the community planning process that the development of these new tools will occur. Following this new tactic will involve risk, but it is only through taking risks that we will create these new, vital opportunities for change.

CHAPTER 4: PRIORITY SETTING CRITERIA

Introduction

As outlined in the CDC Guidance, one of the essential purposes of HIV Prevention Community Planning is to establish a "participatory process which results in programs that are responsive to high priority, community-validated needs within defined populations." The purpose of the Priority Setting Criteria chapter of this plan is to articulate a means to identify these "high priority, community-validated needs."

The following section identifies those criteria for selecting priorities in four areas: target groups, strategies, resource allocation and research. In each area the actual criteria are preceded by guiding principle(s) for using these criteria.

A. PRIORITY TARGET GROUPS

Principle:

> There is only one factor for determining which populations need focused prevention efforts: namely, a significant risk of contracting HIV. Risk of contracting HIV is caused by practicing certain, identifiable, behaviors.

This plan is concerned with the prevalence of HIV in the city of San Francisco.

According to the CDC, as of December, 1993, San Francisco has the highest rate (287.5 per 100,000) of AIDS cases of any metropolitan area in the United States. Therefore, all people in San Francisco who practice behaviors that could lead to the transmission of HIV are at high risk for contracting HIV. For example:

> If a woman has sex with any man in San Francisco her odds of having sex with a man who is HIV-infected are: 1 in 140. If restricted to men who have sex with women this ratio changes to: 1 in 160.
>
> If a man has sex with any man in San Francisco his odds of having sex with a man who is HIV-infected are: 1 in 80. If restricted to men who have sex with men this ratio changes to: 1 in 4.

However, the prevalence of HIV in any population means nothing in the absence of behavior; therefore if we consider all San Franciscans to be at high risk due to

the presence of the virus in our region, we must make efficiency of HIV transmission our next level of criteria. From most effective transmission to least effective within each category, the following are the primary factors for selecting priority target groups.

Primary Factors

BLOOD to BLOOD:
Injection drug use
Perinatal
Cunnilingus during menses
Other blood to blood

SEMEN to BLOOD:
Anal receptive
Anal insertive
Vaginal
Fallatio

VAGINAL Secretion to BLOOD:
Vaginal (female to male)
Cunnilingus

VAGINAL Secretion to VAGINAL (hypothetical: no current epidemiological evidence)

Physiological Co-Factors

Beyond the actual behaviors, co-factors will be considered which increase the risk of contracting HIV with a given behavior. These co-factors are to be used along with the primary factors listed above in determining priority of risk groups. Co-factors include poverty, age, substance use, and other factors which increase the efficiency of transmission of HIV.

For example it has been demonstrated that the health of poor women is compromised by typically inadequate nutrition; in particular, the vaginal walls are weaker and more susceptible to bleeding. Thus, poverty as a co-factor places low-income women at a greater risk than other women for contracting HIV through semen to blood transmission during intercourse.

Substance use has been shown to be linked with various dimensions of decreased health status including thin cell walls, pseudo anemia, and poor nutrition. Age has been linked with decreased resistance to disease in general. Other physiological co-factors may be considered based on scientific evidence.

The presence of more than one behavioral or physiological co-factor may well have a "multiplier-effect" in terms of risk of infection. This issue is not addressed specifically in these criteria beyond the data that currently exists.

Behavioral Co-Factors

The criteria for identifying target risk groups are the behaviors which put people at risk of contracting HIV. The following types of information will be used to inform the identification of groups practicing high risk behaviors, and to better understand the existence and causes for high risk behavior.

Epidemiological data, including incidence and prevalence of HIV, and various surrogate markers provide evidence that high risk behavior is taking place. As the quality and consistency of these measures increases, changes in these measures over time will be one source of data to track changes in behaviors.

Evidence of high risk behavior and attitudes which are linked with high-risk behavior are clearly essential to the identification of relevant priority sub-groups for prevention efforts. Knowledge, Attitudes, Beliefs and Behavior Studies (KABBs), documented program service data and the experience of providers are all sources of information about the extent and nature of high-risk behavior in population sub-groups.

In addition, issues such as low knowledge or situational factors related to high-risk behavior (such as incarceration) are to be considered when establishing and defining the target groups for prevention efforts.

B. SELECTION OF STRATEGIES

Principle:

Strategies will be consistent with the values, norms, and consumer preferences of the intended target population.

Criteria:

- Effectiveness: *evidence of effectiveness will include formal studies, outcome evaluation studies and the experience of providers.*
- Cost effectiveness: *the number of infections averted per dollar spent on prevention.*
- Scientific theory: *theoretical models of behavior change.*
- Speed of implementation: *for example, with a start-up program, if an intervention can be implemented more quickly than an alternative intervention, this is an advantage, all else being equal.*

C. RESOURCE ALLOCATION

Principles:

To prevent as many infections as possible with limited resources, intensive prevention efforts should be targeted to groups and individuals at higher risk. Nonetheless, basic (non-targeted) prevention information and activities must be available at some level to every individual or group no matter how small the risk.

Further, this Planning Council actively supports the mobilization of other resources to assure that all needs are identified and addressed.

Criteria:

These criteria will be applied during the resource allocation process, after priority target populations have been identified, in the development of RFPs and proposal evaluation .

- Size of target population
- The impact of HIV on a given population: *impact is a function of prevalence and size of population. A high prevalence in a small population is of additional concern because of the disproportionate burden borne by that community.*
- Availability of other (non-DPH) resources for priority populations
- Populations historically underserved by HIV prevention activities

D. RESEARCH PRIORITIES

Principle:

The guiding principle for research topics is to find out what we most need to know about populations at high risk and populations which may be at high risk but about which there is little data.

Criteria:

- The effectiveness of various strategies and interventions.
- Populations: examples include service providers know that a population is at risk, but no HIV prevalence data exists for that population, a population's status as historically under-studied, reported increases in demand for services in a population, and significant increases in the rate or absolute number of positive HIV tests or AIDS diagnoses in a population.
- Cost-effectiveness analyses and research on inputs for these analyses.

Copies of the HIV Prevention Plan may be purchased from
San Francisco Department of Public Health
AIDS Office
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102
(415) 554-9000
Monday through Friday 8:00 AM - 5:00 PM
A check in the amount of $20.00 should be made payable to the
San Francisco Public Health Foundation
Please note: Copies will not be mailed.